Review of Employer Subsidy/One-Third Share Plans

March 12, 2003

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Background

Nearly 70% of the uninsured nationally are employed, but either in firms which do not offer health coverage or in which the expense is prohibitive for lower wage workers. A number of local communities have undertaken the development of county-based initiatives to subsidize premiums for workers in firms not providing coverage in order to reduce the numbers of uninsured. Michigan has led the nation in developing these models, with 9 established plans and another 20 in development. In Illinois, Winnebago County (Rockford) and Macoupin County are nearing implementation.

This document outlines the dimensions and issues, and decisions that are involved with the development of an employer-based subsidized plan.

Employer Subsidy/One-Third Share Plans

The key design components for an Employer Subsidy, or One-Third Share, program are employer eligibility criteria, employee eligibility criteria, dependent eligibility criteria, scope of covered benefits and program administration. Each of the existing (and proposed) programs is aimed at low-wage businesses that have been unable to afford the cost of health insurance as an employee benefit. Despite this commonality, the program elements vary greatly from community to community. Each plan reflects a slightly different market approach, scope of services, eligibility/membership options and participation requirements.

Key Program Elements

The design of a subsidized health coverage program is based on the option(s) selected for each of the key features. Each decision element has implications for the marketability of the program as well as the financial risk associated with the program. A summary of essential program design elements and options is outlined in the following table.

Key Element	Options
Program Model	• Insured vs. Non-Insured (Risk vs. non-risk) • Affordability vs. Comprehensive Coverage
Payment Methodology	• Fee-for-Service vs. Capitation (Risk vs. Non-risk)
Benefit Plan Design	• Scope of Coverage • Supplemental riders
Cost Sharing Levels	• Premium Cost vs. Cost Sharing through Deductibles, Coinsurance, or Copayments
Employer, Employee, and Dependent Qualifiers	• Wage • Location – Residence/Work • Business size • Work history • Pre-existing conditions • Amount of dependent coverage/subsidy
General Administrative Options	• Annual Open Enrollment • Proof of Employment • Cut off dates for new hires and qualifying events • Documentation requirements to verify address and qualifying events

The size of the program is also something that must be considered during program development. The magnitude of the funds available for this program, coupled with decisions made regarding benefit design, size of subsidy and dependent coverage will dictate how many employees (and dependents) may be covered.

Insurance versus Coverage

Insured products, although usually higher in price, eliminate risk from the program. Since the program would not be a self-funded plan, in an insurance model the insurer would assume the risk for the costs for the provision of health care benefits under the plan. In a "coverage" (non-insured) model, risk can often be transferred. One model in Michigan has been able to contract with health care entities that are not licensed insurers[1] and assign all of the risk through use of capitation payments.

[1] The HealthChoice providers in Wayne County are generally non-licensed subsidiaries of licensed insurers.

An essential issue for employers and employees is affordability. Adding a subsidy for one-third of the cost makes health coverage much more affordable, but may not be enough for some employers and for many low-wage employees. Non-insured products offer much greater flexibility in coverage options, and, subsequently, in the cost of the product. In Michigan, covered benefits can be significantly more restrictive than the minimum coverage requirements under insurance laws that apply to licensed insurers and HMOs. The ability to reduce the scope of benefits under a non-insured product can result in affordable premiums with "first dollar" coverage, thereby avoiding high deductibles that must be met before the enrollee receives any assistance with the costs of health care. Illinois insurance regulations are less flexible.

Payment Methodology

In a subsidized insurance model the subsidy represents a share of the insurance premium paid to the insurance company. The HealthChoice program in Wayne County makes capitation payments to the HealthChoice managed care companies, based on family size and riders that the enrollee has chosen. All financial risk and the process of paying health care providers are the responsibility of the managed care company. The Access Health program in Muskegon County uses a fee-for-service model. Providers that are part of the Access Health network receive payment under an established fee schedule for each service they provide. No providers under the Access Health program are capitated.

Qualifiers for Employers, Employees and Dependents

Determining qualifiers for employers, employees and dependents is key in obtaining an actuarially viable population. The criteria adopted for employer and employee eligibility also influence the cost of the program, marketability and the size of potential enrollment. For example, allowing continuous open enrollment without a pre-existing condition exclusion permits people to enroll only when a service is needed and disenroll when the service is no longer required. Establishing a minimum group (employee) size can prevent fraud in the application process and provide some protection against adverse selection. Implementing a "recertification" process and/or maximum term of participation for employers provides protections related to continued eligibility.

Benefit Design Options and Cost Sharing Options

Insured products are typically more comprehensive in coverage because they must meet commercial licensure standards. Non-insured products offer more flexibility in benefit design. Benefit designs and cost-sharing levels will help determine the marketability of the program and will likely impact utilization of certain services. For example, large deductibles can discourage use of unnecessary health care services, but can also discourage use of primary and preventive care. It is unlikely that a low-income employee would select a program that has large deductibles. While copayments and/or coinsurance are more marketable and may also reduce unnecessary utilization, they may result in delays in receipt of necessary care due to an enrollee's inability to meet the financial obligation on top of the monthly premiums. Supplemental riders can be used to limit the benefits in the basic plan, while maintaining the marketability of the program if the supplements are low cost.

Program Models

Program models vary greatly in terms of insurance versus coverage, scope of benefits, qualifications for employers and employees and governance structure. In Michigan, local governments are permitted to organize systems of care that are not insured products. One advantage these types of products have is greater affordability because they can offer less comprehensive coverage than the insurance code allows. Additional benefits, such as additional inpatient hospital days or dental care, can be purchased through individual riders to augment the basic product. Unfortunately, current Illinois insurance law does not provide the same flexibility as Michigan, and offerings being developed for Winnebago and Macoupin Counties have been filed insurance offerings.

The Wayne County Model

Wayne County began administering its employer subsidy program through Wayne County's HealthChoice program during 1994. HealthChoice benefits are delivered through seven contracted Managed Care Organizations (MCOs). MCOs are unlicensed subsidiaries of licensed HMOs. MCOs are responsible for claims processing, case management, quality assurance and patient education. Funding is capitated and the MCOs and/or their contracted providers are at risk for the cost of delivered services. Current plan enrollment includes roughly 12,000 contracts covering just under 22,000 members. Wayne County contracts with a group benefit plan

administrator. Another contractor provides administrative services such quality assurance, policy, carrier procurement, and finance and marketing.

The Muskegon County Model

Muskegon County began administering its employer subsidy program through Access Health in the spring of 1999. Access Health is a 501 (m) corporation and is incorporated under Michigan's Municipal Health Facilities Corporation Act. An eight-member community board governs Access Health. Access Health intends to subsidize 3,000 enrollees; enrollment is currently about 800 members.

Access Health is not an insured product. Benefits are delivered through a contracted, county-wide provider network. Members select a primary care physician. It is the responsibility of primary care physicians to refer patients for specialty care, diagnostic tests and other necessary services. Care is only covered within Muskegon County. Services received outside of the county, including emergency services and specialty services not available within the county, are not covered. Three Access Health full-time employees provide case management services.

Providers are paid fee-for-service, minus applicable copayments and a 10% provider donation toward the member's total cost of coverage.

Access Health members enroll through their employer. A contracted Third Party Administrator (TPA) processes claims.

The Ingham County Model

Ingham County established the Ingham Health Plan Corporation (IHP) as a 501(c)(3) non-profit organization. IHP is responsible for contracting with a single qualified health insurer to administer the IHP Subsidized Health Insurance Program. A Request for Proposal was issued in mid-2001; responses continue to be under consideration. The selected qualified health insurer will offer one or more health insurance products designed to meet the needs of small employers. IHP anticipates implementing the program during 2001. IHP expects to limit subsidies to 2,500 enrollees and anticipates reaching that enrollment by 2004. Many details of the program, and possibly some significant program design decisions, are subject to change and further approval as implementation nears.

The qualified insurer will accept the monthly subsidy payment as payment in full for providing (or arranging provision of) all covered services to enrollees. The qualified insurer will contract with health care providers and be responsible for all payment to providers. The qualified insurer will have sole responsibility for the sales and administration of the program. The qualified insurer will bill the employee for the premium. The employee will contribute through payroll deduction. IHP will be responsible for marketing, although some marketing activities will be conducted jointly.

The Kent County Model

Kent Health Plan Corporation (KHPC) was established in 2001 as a 501(c)(4) non-profit organization. A Request for Proposal was issued in January 2002 with responses due in early February. The selected bidder will offer a product designed to meet the needs of small employers. KHPC anticipates implementing the program during the third quarter of 2002. KHPC expects to limit subsidies to 2,500 enrollees and anticipates reaching that enrollment by 2004. Many details of the program, and possibly some significant program design decisions, are subject to change and further approval as implementation nears.

While it is not essential that an interested bidder assume the risk for the cost of services, significant preference will be given to entities willing to bear risk.

Coverage will include physician services, inpatient and outpatient hospital services (including emergent and urgent care), ancillary services and prescription coverage. With the exception of laboratory and radiology services, all services have copayments. The prescription coverage is limited to the drugs on the KHPC formulary for its Plan B program (low-income, uninsured persons).

The Winnebago County Model[2]

The Health Access Plan (HAP) was established in December 2002 as a not-for-profit corporation, a subsidiary of the Rockford Health Council, Inc (RHC). RHC and HAP have designed a One-Third Share premium subsidy program based upon models developed in

[2] Winnebago County Model information provided by Raymond W. Empereur, M.P.A., Executive Director, Rockford Health Council

Michigan. One major difference is that in Illinois the plan will be an insurance product underwritten by Pan American Life Insurance of Louisiana as their American Worker Plan. Illinois insurance law does not permit the concept of "coverage" versus insurance as defined in Michigan. The Health Access Premium Subsidy Plan will be launched in the Spring of 2003, a first for Illinois.

Much as in similar plans, eligible employers will be those based in Winnebago County that: 1) Are small businesses with between 3 and 25 employees, 2) Not having offered health insurance for the last 12 months, and 3) Having a median work force wage of $12.00 per hour or less. HAP expects to serve 5,000 people when fully developed in 5 years, assuming a permanent method is found to support the premium subsidy. During the first year the subsidy will be supported by a grant from the US Small Business Administration.

Coverage, while modest, will include outpatient office visits, wellness care, prescription drugs, diagnostic x-ray and lab, and some inpatient and surgical coverage. The monthly premium of $150 will be split so that the employer and employee each pay $50 and the subsidy pays $50. Since many families who participate will be eligible for KidCare, the plan will also facilitate enrollment in this public plan.

The Macoupin County Model

Health Management Associates (HMA) started working with Macoupin County Public Health Department in Fall 2002, to design a health insurance program for small businesses in the County. Activities are similar to those performed in Rockford and include:

- Identification of community needs and development of concept for the appropriate indigent care program. Like Rockford, Macoupin decided to go with a small employer-based, third-share model;
- Development/creation of the nonprofit corporation (including its governance and administrative structure);
- Development of program specifications (benefit structure);
- Development of overall program and financing strategy, including continued review and identification of local funds that qualify as matching funds;

- Budget development and refinements;
- Development of RFP and negotiations with bidders (insurance companies);
- Development and management of relationships with the Illinois Department of Insurance;
- Analysis of utilization and cost trends for potential plan enrollees;
- Assistance with design of program administration; and
- Attendance at planning meetings until implementation completed.

Currently, Macoupin County is in the process of selecting a vendor to offer the third-share plan. The estimated implementation date is Spring 2003. Macoupin County's third-share plan will most likely resemble a hospital plan with limited professional benefits such as: outpatient office visits, wellness care, prescription drugs, diagnostic x-ray and lab, home health, skill nursing facilities, and inpatient and surgical coverage.